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August 31, 2020

Honorable Alison J. Nathan
United States Courthouse
40 Foley Square Courtroom 906
New York, NY 10007

Re: United States v. John Geraci 18-CR-00715

Dear: Judge Nathan

We file this letter to respectfully request a three-day continuance of the September 1, 2020, surrender date for Mr. John Geraci to September 4, 2020, to allow Mr. Geraci to attend a doctor's appointment and obtain a diagnosis and treatment plan for spinal issues. This Court previously granted a continuance of Mr. Geraci's surrender date from March 23, 2020 to May 1, 2020, from May 1, 2020 to July 1, 2020 and from July 1, 2020 to September 1, 2020. See Dkt. Nos. 78, 80, 82.

In recent months, Mr. Geraci has suffered, and continues to suffer, from several health issues. In March, Mr. Geraci was hospitalized at Baptist Health South Florida Hospital. He was later diagnosed with pneumonia and treated remotely, via virtual medical appointments, and antibiotics. Mr. Geraci later reported that he was diagnosed with a second case of pneumonia and despite treatment, was forced to return to the hospital on June 26, 2020. At this time, in addition to his pneumonia, preliminary tests revealed that Mr. Geraci had suffered a small stroke in his brain called a TIA, which Mr. Geraci informed counsel was likely due to his atrial fibrillation. Further tests revealed lung nodules, and coronary artery disease. Moreover, as a result of his coronary artery disease, and as recognized by the CDC, Mr. Geraci is at an increased risk of severe illness should he contract COVID-19.

On August 27, Mr. Geraci was once again admitted to the hospital, this time due to numbness in his arms and legs. He was released on August 30, with orders to see a specialist as soon as possible for further diagnoses and treatment. Mr. Geraci reports that the doctors suspect the numbness is related to a prior spinal surgery where a screw has now shifted and is protruding

into the spinal column. If this suspicion is confirmed, Mr. Geraci believes he will need surgery immediately. Mr. Geraci has requested his medical records for the specialist to review (*see* Ex. A) and we will alert the court as an appointment with the specialist is set.

Assistant United States Attorneys for the District of New York Drew Skinner and Jared Lenow have been notified of this request.

For the above-stated reasons, Counsel for Mr. Geraci, respectfully requests a continuation of Mr. Geraci's surrender date from **September 1, 2020 to September 4, 2020**.

SO ORDERED.

8/31/2020
SO ORDERED.
ALISON J. NATHAN, U.S.D.J.

Sincerely,
Marissa E. Miller

/s/ *Marissa E. Miller*
Lyn R. Agre

/s/ Lyn R. Agre
Counsel for John Geraci

Medical Record #

JACKSON HEALTH SYSTEM
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

PATIENT NAME: JOHN GERACI

DATE OF BIRTH: 4-25-1957 TREATMENT DATE(S): 8/27/20 – 8/29/20

PHONE NUMBER: [redacted] EMAIL ADDRESS: jgeraci@meridiancapital.net

1. Please note that:

- The Public Health Trust is required by federal and state law to protect your health information.
- The person or organization that receives your health information may not be required by federal law to protect it and may share your information with others without your permission. The person or organization that receives your health information may be required under state law to use your information only for the purpose you stated and may not share your information without your written permission. In particular, the receiving person or organization may not be allowed to share any information about HIV test results, substance abuse, psychiatric/psychotherapy or sexual assault without your permission.
- The Trust cannot condition your treatment, payment, enrollment or eligibility for benefits on whether or not you sign this Authorization.
- You do not have to sign this Authorization form, but if you do not, we will not provide your health information to the person or organization you have requested.
- You may change your mind and revoke (take back) this Authorization at any time. If the Trust has not yet released your health information and you change your mind, it will not release your information. However, if the Trust relied on this Authorization before you changed your mind and released your health information, the person we gave it to may still disclose the health information they have already received. The Trust relied on this Authorization if the Trust had forwarded your health information to the person or organization that you requested.
- To revoke this Authorization you must write to the Health Information Office at Jackson Health System, Jackson 1611 N.W. 12th Avenue, Miami, Florida 33136 Building ACC-West Basement Floor Room# L-129.
- Your permission to release your health information will automatically expire twelve (12) months from the date that you signed this form, unless you revoke your permission earlier or you choose a different date: _____(list a specific date or event - e.g., at the end of the research study, six months from now, etc.).

2. I JOHN GERACI (patient/authorized representative) give permission to the Public Health Trust of Miami- Dade County/Jackson Health System to release health information that identifies John Geraci patient (Select one of the following):

Delivery Method: ☐ Mail or ☐ Pick-Up **Record Format:** ☐ Paper ☑ Email ☐ CD ☐ Fax (Medical Facilities Only)

a. ✓ Complete Medical Record (covering the period(s) of: 8/27/20–8/29/20)
(Please note that by selecting this option this will not provide you with your billing records. In order to request your billing records, please select option 2.c. HIV test results may be released with the Complete Medical Record if you have signed a prior written authorization to release HIV test results.): **OR**

b. ____ Complete Psychiatric/Psychotherapy Record (covering the period(s) of: _____): **OR**

c. ____ Billing Records (covering the period(s) of: _____)

d. ✓ Release shall be limited to the following specific types of information (covering the period(s) of: 8/27/20 – 8/29/20):

- ✓ Discharge Summary
- ✓ Emergency Department Record
- ✓ Progress Notes
- ✓ Operative Reports
- ✓ Pathology Reports
- ✓ EKG Reports
- ✓ X-Rays or Other Imaging Reports
- ____ Autopsy Report
- ✓ Consultation Report
- ✓ Laboratory Test Results
- ✓ History and Physical Examination
- ____ Outpatient Records

e. ____ Other (Specify): _____.

3. I, _____ give specific consent to release my medical records that relate to the following areas (please sign your name next to all that apply):
Patient/Authorized Representative

_____ HIV Test Results _____ Substance Abuse _____ Sexual Assault

4. **The purpose for which my health information is being released is: (please initial)**

✓ Continuing Care _____ Legal _____ Insurance _____ Personal _____ Other: _____

5. **I give permission for the health information listed above to be released to the following individual(s), organization(s) or entity(ies):**

Name: _____ Phone: _____

Address: _____ Fax: _____; **OR**

Name: _____ Phone: _____

Address: _____ Fax: _____; **OR**

Name: _____ Phone: _____

Address: _____ Fax: _____; **OR**

Name: _____ Phone: _____

Address: _____ Fax: _____; **OR**

Name: _____ Phone: _____

Address: _____ Fax: _____; **OR**

John D. Lewis 8/31/20
Patient Signature Date

Parent/Authorized Representative – sign and print

Indicate Relationship to Patient

PATIENT IMPRINT

Jackson HEALTH SYSTEM PUBLIC HEALTH TRUST MIAMI, FLORIDA 33136-1096

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS